		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028522

Facility Name: The Carle Arbours

Address: 302 Burwash (Number) Savoy (City) 61874 (Zip Code)

County: Champaign

Telephone Number: 217-383-3098 **Fax #** 217-383-3194

IDPA ID Number: 371155535001

Date of Initial License for Current Owners: 02/01/84

Type of Ownership:

[x]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Kerry G. Frerichs **Telephone Number:** 217-383-4784

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JAMES SNIDER

(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 02/06/04

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	240	Skilled (SNF)	231	86,526	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	240	TOTALS	231	86,526	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,586	1,221	7,727	14,534	8
9	SNF/PED					9
10	ICF	19,333	25,851		45,184	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,919	27,072	7,727	59,718	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.02%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 53 and days of care provided 7,727

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	421,947	30,960		452,907		452,907	(1,302)	451,605			1
2	Food Purchase		334,669		334,669		334,669	(600)	334,069			2
3	Housekeeping	185,843	32,132		217,975		217,975		217,975			3
4	Laundry	75,081	12,175	9,165	96,421		96,421		96,421			4
5	Heat and Other Utilities			183,732	183,732	(7,052)	176,680		176,680			5
6	Maintenance	23,357	31,090	62,403	116,850	(14,151)	102,699	455	103,154			6
7	Other (specify):*					41,657	41,657		41,657			7
8	**TOTAL General Services**	706,228	441,026	255,300	1,402,554	20,454	1,423,008	(1,447)	1,421,561			8
	B. Health Care and Programs											
9	Medical Director			9,452	9,452		9,452		9,452			9
10	Nursing and Medical Records	2,495,964	313,533	905,821	3,715,318	51,565	3,766,883	(752)	3,766,131			10
10a	Therapy	50,643	5,259	624,547	680,449	(20,548)	659,901		659,901			10a
11	Activities	107,201	9,161	3,226	119,588		119,588	(8,328)	111,260			11
12	Social Services	119,113			119,113		119,113		119,113			12
13	Nurse Aide Training											13
14	Program Transportation			43	43	1,245	1,288		1,288			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,772,921	327,953	1,543,089	4,643,963	32,262	4,676,225	(9,080)	4,667,145			16
	C. General Administration											
17	Administrative			288,482	288,482		288,482	708,094	996,576			17
18	Directors Fees											18
19	Professional Services			247,610	247,610		247,610	(228,000)	19,610			19
20	Dues, Fees, Subscriptions & Promotions			85,688	85,688	9,304	94,992	(61,481)	33,511			20
21	Clerical & General Office Expenses	221,850	26,128	164,837	412,815	(52,031)	360,784	(49,382)	311,402			21
22	Employee Benefits & Payroll Taxes			972,384	972,384		972,384		972,384			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,224	10,224	(3,013)	7,211	(4,131)	3,080			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			154,226	154,226	100	154,326		154,326			26
27	Other (specify):*											27
28	**TOTAL General Administration**	221,850	26,128	1,923,451	2,171,429	(45,640)	2,125,789	365,100	2,490,889			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,700,999	795,107	3,721,840	8,217,946	7,076	8,225,022	354,573	8,579,595			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Carle Arbours #0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			379,578	379,578		379,578	(5,561)	374,017			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			514,704	514,704		514,704	(1,185)	513,519			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			(32)	(32)	490	458		458			35
36	Other (specify):* Shared A & G Hosp							30,867	30,867			36
37	**TOTAL Ownership**			894,250	894,250	490	894,740	24,121	918,861			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,240,227		1,240,227	510	1,240,737	441,920	1,682,657			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,866	137,866	(8,076)	129,790		129,790			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		1,240,227	137,866	1,378,093	(7,566)	1,370,527	441,920	1,812,447			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,700,999	2,035,334	4,753,956	10,490,289		10,490,289	820,614	11,310,903			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,302)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(60)	21		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,185)	32		10
11	Discounts, Allowances, Rebates & Refunds	(597)	10		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(5,561)	30		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,030)	11		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,574)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,432)	21		24
25	Fund Raising, Advertising and Promotional	(61,481)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(12,184)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (140,406)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	961,020		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 961,020		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 820,614		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

The Carle Arbours

ID# 0028522

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Direct Care Travel	$ (4,131)	24	1
2	Food Service Rebate	(600)	2	2
3	Activity Income	(7,298)	11	3
4	UnAllowable Nursing	(155)	10	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(12,184)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,302)	0	0	0	0	0	0	0	0	0	0	(1,302)	1
2	Food Purchase	(600)	0	0	0	0	0	0	0	0	0	0	(600)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	455	0	0	0	0	0	0	0	0	0	455	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,902)	455	0	0	0	0	0	0	0	0	0	(1,447)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(752)	0	0	0	0	0	0	0	0	0	0	(752)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(8,328)	0	0	0	0	0	0	0	0	0	0	(8,328)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,080)	0	0	0	0	0	0	0	0	0	0	(9,080)	16
	C. General Administration													
17	Administrative	0	708,094	0	0	0	0	0	0	0	0	0	708,094	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,574)	(218,426)	0	0	0	0	0	0	0	0	0	(228,000)	19
20	Fees, Subscriptions & Promotions	(61,481)	0	0	0	0	0	0	0	0	0	0	(61,481)	20
21	Clerical & General Office Expenses	(47,492)	(1,890)	0	0	0	0	0	0	0	0	0	(49,382)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,131)	0	0	0	0	0	0	0	0	0	0	(4,131)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(122,678)	487,778	0	0	0	0	0	0	0	0	0	365,100	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(133,660)	488,233	0	0	0	0	0	0	0	0	0	354,573	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number The Carle Arbours **#** 0028522 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(5,561)	0	0	0	0	0	0	0	0	0	0	(5,561)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,185)	0	0	0	0	0	0	0	0	0	0	(1,185)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	30,867	0	0	0	0	0	0	0	0	0	30,867	36
37	**TOTAL Ownership**	(6,746)	30,867	0	0	0	0	0	0	0	0	0	24,121	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	441,920	0	0	0	0	0	0	0	0	0	441,920	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	441,920	0	0	0	0	0	0	0	0	0	441,920	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(140,406)	961,020	0	0	0	0	0	0	0	0	0	820,614	45

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
The Carle Foundation	100			Carle Hospital	Urbana	Hospital/DME/Rx
				Carle HealthCare	Urbana	Ambulance

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Home Office-Misc. Gen. Svcs	$	Carle Foundation	100.00%	$ 455	$ 455	1
2	V	17	Home Office-Administrative		Carle Foundation	100.00%	131,303	131,303	2
3	V	17	Shared A & G Hosp Gen. Svcs.		Carle Foundation	100.00%	576,791	576,791	3
4	V	19	Home Office-Other Prof. Fees		Carle Foundation	100.00%	13,354	13,354	4
5	V	21	Home Office-Purch. Svcs.		Carle Foundation	100.00%	(2,604)	(2,604)	5
6	V	21	Home Office-Operating Supp.		Carle Foundation	100.00%	714	714	6
7	V	36	Shared A & G Hosp Capital		Carle Foundation	100.00%	38,417	38,417	7
8	V	19	Management Fees	231,780	Carle Foundation	100.00%		(231,780)	8
9	V	10a	PT, OT & ST	624,547	Carle Foundation	100.00%	624,547		9
10	V	39	Parmacy & Drugs	1,004,364	Carle Foundation	100.00%	1,446,284	441,920	10
11	V	36	Home Office - Loss/Gain on Disp		Carle Foundation	100.00%	(7,550)	(7,550)	11
12	V								12
13	V								13
14	Total			$ 1,860,691			$ 2,821,711	$ * 961,020	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: The Carle Foundation
Street Address: 611 W. Park St.
City / State / Zip Code: Urbana, IL 61801
Phone Number: (217-383-4718
Fax Number: (217-383-4588

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Home Office-Misc. Gen. Svcs	Direct Costs	12	12	$ 455	$	12	$ 455	1
2	17	Home Office-Administrative	Direct Costs	12	12	131,303	102,857	12	131,303	2
3	17	Shared A & G Hosp Gen. Svcs.	Direct Costs	12	12	576,791	265,728	12	576,791	3
4	19	Home Office-Other Prof. Fees	Direct Costs	12	12	13,354		12	13,354	4
5	21	Home Office-Purch. Svcs.	Direct Costs	12	12	(2,604)		12	(2,604)	5
6	21	Home Office-Operating Supp.	Direct Costs	12	12	714		12	714	6
7	36	Shared A & G Hosp Capital	Direct Costs	12	12	38,417		12	38,417	7
8	36	Home Office - Gain/Loss on Disp	Direct Costs	12	12	(7,550)		12	(7,550)	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 750,880	$ 368,585		$ 750,880	25

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	$26.00 Million Bond Issue	x		Refinance/Remodel	N/A	06/01/96	$ 1,086,927	$ 947,699	Multiple	Variable	$ 60,672	1
2	$49.99 Million Bond Issue	x		Refin/Remod/Arbrs Ct	N/A	05/01/98	6,967,497	6,289,278	Multiple	Variable	302,131	2
3	$29.30 Million Bond Issue	x		Refinance/Remodel	N/A	07/01/99	253,671	232,027	Multiple	Variable	3,361	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	**TOTAL Facility Related**						$ 8,308,095	$ 7,469,004			$ 366,164	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 8,308,095	$ 7,469,004			$ 366,164	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Carle Arbours COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0028522

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,118 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	174,240	1984	$ 274,934	1
2					2
3	TOTALS	174,240		$ 274,934	3

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	231		1984	1973	$ 2,967,466	$ 84,785	35	$ 84,785	$	$ 1,731,022	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	RENOVATIONS			1984	267,128	9,152	VARIOUS	9,152		221,436	9
10	WINDOWS			1984	6,326		VARIOUS			6,326	10
11	SIGNS & A/C			1984	15,232		VARIOUS			15,232	11
12	LANDSCAPING			1985	13,589		VARIOUS			13,589	12
13	PLUMBING			1985	34,747	1,390	VARIOUS	1,390		26,732	13
14	ROOF & ELECTRICAL			1985	23,658	262	VARIOUS	262		22,341	14
15	KITCHEN REMODEL			1985	23,504	693	VARIOUS	693		19,738	15
16	LANDSCAPING			1986	7,325		VARIOUS			7,325	16
17	RENOVATIONS			1986	31,097	786	VARIOUS	786		25,791	17
18	LANDSCAPING			1987	2,032	11	VARIOUS	11		2,032	18
19	ROOF REPAIR			1987	749		VARIOUS			749	19
20	CARPET			1987	6,689		VARIOUS			6,689	20
21	RENOVATIONS			1987	28,041	10	VARIOUS	10		28,041	21
22	CARPET & FLOORING			1988	21,483		VARIOUS			21,483	22
23	ALZHEIMERS ADDITION			1988	1,400	47	VARIOUS	47		751	23
24	GENERATOR			1988	11,693	275	VARIOUS	275		10,570	24
25	INSULATION			1988	3,650	183	VARIOUS	183		2,935	25
26	RENOVATIONS			1988	6,774	8	VARIOUS	8		6,666	26
27	ALZHEIMERS/2ND FLOOR RENOVATION			1990	6,214	301	VARIOUS	301		4,511	27
28	EMERGENCY POWER DISTRIBUTION			1990	27,115	1,334	VARIOUS	1,334		18,797	28
29	DOORS			1990	1,388	93	VARIOUS	93		1,326	29
30	REMODELING			1990	2,838	142	VARIOUS	142		1,939	30
31	REMODELING			1991	472,549	20,454	VARIOUS	20,454		267,328	31
32	FLOORING			1991	87,008	2,547	VARIOUS	2,547		68,116	32
33	RENOVATIONS			1991	1,981	49	VARIOUS	49		1,621	33
34	RENOVATIONS			1992	5,150	343	VARIOUS	343		4,106	34
35	ROOF REPAIR			1992	22,257		VARIOUS			22,257	35
36	FLOORING			1992	14,427	702	VARIOUS	702		12,087	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LANDSCAPING	1992	$ 4,734	$	VARIOUS	$	$	$ 4,734	37
38	OUTDOOR LIGHTING	1993	8,352	557	VARIOUS	557		6,218	38
39	ELEVATOR	1993	10,788	561	VARIOUS	561		6,278	39
40	REMODELING	1993	48,830	2,384	VARIOUS	2,384		26,636	40
41	PARKING LOT IMPROVEMENTS	1994	4,300	72	VARIOUS	72		4,300	41
42	ELEVATOR	1994	3,368	168	VARIOUS	168		1,768	42
43	RENOVATIONS	1994	57,905	2,993	VARIOUS	2,993		32,231	43
44	PARKING LOT IMPROVEMENTS	1995	11,934	1,151	VARIOUS	1,151		10,555	44
45	REMODELING	1994	55,764	2,839	VARIOUS	2,839		27,468	45
46	DOORS	1994	4,684	232	VARIOUS	232		2,716	46
47	REMODELING	1995	2,320		VARIOUS			2,320	47
48	REMODELING	1995	12,720	785	VARIOUS	785		4,834	48
49	ROOF REPAIRS	1995	20,660	1,065	VARIOUS	1,065		9,679	49
50	ROOF AIR CONDITIONER	1995	40,354	3,558	VARIOUS	3,558		31,294	50
51	ROOF AIR CONDITIONER	1995	2,950	295	VARIOUS	295		2,483	51
52	RENOVATIONS - KITCHEN/DINING	1995	264,018	14,668	VARIOUS	14,668		127,120	52
53	RENOVATIONS - KITCHEN/DINING	1996	5,613	312	VARIOUS	312		2,572	53
54	RENOVATIONS - BATHROOM	1996	79,899	3,995	VARIOUS	3,995		32,625	54
55	FLOORING	1996	15,511	1,551	VARIOUS	1,551		12,538	55
56	WINDOWS	1996	3,028	151	VARIOUS	151		1,174	56
57	ENTRANCE CANOPY	1996	1,580	158	VARIOUS	158		1,211	57
58	ELECTRIC DOORS	1996	5,072	437	VARIOUS	437		3,347	58
59	ROOFING	1996	22,900	2,290	VARIOUS	2,290		17,557	59
60	REPAIR BOILER ROOM	1996	3,300	330	VARIOUS	330		2,530	60
61	REFURBISH SIGN	1996	1,200	120	VARIOUS	120		920	61
62	ENTRANCE CANOPY	1997	3,693	369	VARIOUS	369		2,739	62
63	NURSE STATIONS	1997	34,011	2,126	VARIOUS	2,126		13,995	63
64	FENCE	1998	3,885	259	VARIOUS	259		1,619	64
65	DOORS	1998	945	63	VARIOUS	63		357	65
66	NURSE STATIONS	1998	10,000	667	VARIOUS	667		3,779	66
67	CHAIN LINK FENCE	1998	4,544	303	VARIOUS	303		1,742	67
68	BATHS	1999	623,243	31,162	VARIOUS	31,162		163,602	68
69	WALL ARCHITECTURAL	1999	1,491	75	VARIOUS	75		379	69
70	TOTAL (lines 4 thru 69)		$ 5,487,106	$ 199,263		$ 199,263	$	$ 3,134,856	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,487,106	$ 199,263		$ 199,263	$	$ 3,134,856	1
2	SUBACUTE IMPROVEMENTS	2000	75,624	4,020		4,020		17,754	2
3	RENOVATIONS- BATHROOMS	2000	36,055	1,898		1,898		8,381	3
4	HANDRAILS	2000	11,693	780		780		3,443	4
5	HALL FLOOR	2000	30,472	1,604		1,604		7,084	5
6	ROOF REPAIRS	2000	7,800	433		433		1,697	6
7	AIR CURTAIN	2000	1,110	62		62		242	7
8	BATH RENOVATION	2000	2,438	128		128		502	8
9	SECOND FLOOR AIR	2000	4,829	268		268		961	9
10	FACILITY IMPROVEMENTS	2001	274	55		55		169	10
11	THERAPY FLOOR	2001	3,700	370		370		1,079	11
12	THERAPY CEILING	2001	3,194	639		639		1,863	12
13	FIRST FLOOR HANDRAILS	2001	12,480	2,496		2,496		6,448	13
14	SECOND FLOOR AIR	2002	86,210	5,129		5,129		10,903	14
15	WALL ARCHITECHURAL	2002	7,032	414		414		1,034	15
16	GIFT SHOP EXPANSION	2002	16,819	1,066		1,066		2,620	16
17	CARPET	2002	3,984	797		797		1,859	17
18	THERAPY FLOOR	2002	180	18		18		41	18
19	VINYL FLOORING	2002	5,979	598		598		1,246	19
20	THERAPY CEILING	2002	6,930	1,386		1,386		2,888	20
21	NURSE STATIONS(PER FY99 IPA AUDIT)	1995	69,094	3,839		3,839		33,907	21
22	RENOVATIONS-FIRE WALL	2003	146,487	6,972		6,972		12,462	22
23	ARBRS COURT BUILDING	2003	1,397,938	34,950		34,950		37,760	23
24	RENOVATIONS-NURSING STATION/TEMP CONTROLLERS	2003	57,666	1,442		1,442		1,564	24
25	FLOORING	2003	7,490	1,098		1,098		1,905	25
26	ARBRS COURT BUILDING	2004	344,851	6,466		6,466		6,466	26
27	FENCING	2004	7,172	275		275		275	27
28	LANDSCAPING	2004	80,580	8,820		8,820		8,820	28
29	ORIG BLDG RENOVATIONS	2004	83,766	1,275		1,275		1,275	29
30	RENOVATIONS	2004	75,994	1,408		1,408		1,408	30
31	SINAGE	2004	6,427	922		922		922	31
32	ROUNDING		(2)					(1)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,081,372	$ 288,891		$ 288,891	$	$ 3,311,833	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,488,842	$ 72,571	$ 72,571	$		$ 1,187,647	71
72	Current Year Purchases	199,814	12,555	12,555			12,555	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,688,656	$ 85,126	$ 85,126	$		$ 1,200,202	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,044,962	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 374,017	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 374,017	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,512,035	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NURSE STATIONS-1997&1998	$ 49,545	$ 3,096	$ 20,266	86
87	BATHS-1999	9,818	491	2,577	87
88	NURSING HOME FINDERS FEE-1984	38,500	1,540	31,442	88
89	PROJECT 95-028-00-1997	6,940	434	2,856	89
90	EQUIP-BEDS-1983	1,690	--	1,690	90
91	TOTALS	$ 106,493	$ 5,561	$ 58,831	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a Col 3	hrs	$	6,353	$ 228,596	$	6,353	$ 228,596	1
2	Licensed Speech and Language Development Therapist	Line 10a Col 3	hrs		1,207	47,823		1,207	47,823	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col 3	hrs		9,650	348,128		9,650	348,128	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39 Col 2	# of prescrpts				1,240,227		1,240,227	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	17,210	$ 624,547	$ 1,240,227	17,210	$ 1,864,774	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number The Carle Arbours **#** 0028522 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/04 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 33,597	$	1
2	Cash-Patient Deposits	22,429		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	883,899		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	769,861		5
6	Prepaid Insurance	44,871		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(4,146,817)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (2,392,160)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Rounding	1		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ (2,392,159)	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 463,067	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	191,051		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Rounding	1		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 654,119	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 654,119	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,046,278)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (2,392,159)	$	48

***(See instructions.)**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,874,461)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,874,461)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,217,439)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Partnership Revenue**	45,627	15
16	Other (describe) **Rounding**	(5)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,171,817)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,046,278)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,431,128	1
2	Discounts and Allowances for all Levels	(4,475,911)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,955,217	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,075,050	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,075,050	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	10,535	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	600	13
14	Non-Patient Meals	1,302	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	25,500	16
17	Sale of Drugs	1,195,566	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,233,503	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,185	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,185	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Discounts	597	28
28a	Activities & Programs	7,298	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,895	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,272,850	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,402,554	31
32	Health Care	4,643,963	32
33	General Administration	2,171,429	33
	B. Capital Expense		
34	Ownership	894,250	34
	C. Ancillary Expense		
35	Special Cost Centers	1,240,227	35
36	Provider Participation Fee	137,866	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,490,289	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,217,439)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,217,439)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,832	2,080	$ 62,770	$ 30.18	1
2	Assistant Director of Nursing	1,904	2,080	54,660	26.28	2
3	Registered Nurses	16,719	17,679	436,123	24.67	3
4	Licensed Practical Nurses	35,699	39,004	704,807	18.07	4
5	Nurse Aides & Orderlies	91,396	100,518	1,153,987	11.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,727	4,153	50,549	12.17	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,548	2,086	31,581	15.14	9
10	Activity Assistants	6,759	7,670	75,619	9.86	10
11	Social Service Workers	6,072	6,240	119,113	19.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,011	2,076	42,881	20.66	14
15	Cook Helpers/Assistants	33,875	36,768	379,065	10.31	15
16	Dishwashers					16
17	Maintenance Workers	2,065	2,291	23,357	10.20	17
18	Housekeepers	17,460	18,962	185,843	9.80	18
19	Laundry	7,535	8,248	75,081	9.10	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,880	1,992	41,255	20.71	22
23	Office Manager					23
24	Clerical	11,251	12,851	176,920	13.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,744	6,532	87,388	13.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	247,477	271,230	$ 3,700,999 *	$ 13.65	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	N/A	9,452	Ln 9 Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,452		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,921	$ 154,894	Ln 10 Col 3	50
51	Licensed Practical Nurses	7,796	264,995	Ln 10 Col 3	51
52	Nurse Aides	17,804	426,709	Ln 10 Col 3	52
53	TOTAL (lines 50 - 52)	29,521	$ 846,598		53

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
J. Snider	Administrator	0	$ 87,858
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,858

B. Administrative - Other

Description	Amount
Heritage Enterprises	$ 278,908
Hartweg, Turner	9,574
TOTAL (agree to Schedule V, line 17, col. 3)	$ 288,482
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Carle Hospital	Related party	$ 231,780
Carle Clinic Assoc	Data Processing	15,830
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 247,610

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,258
Unemployment Compensation Insurance	8,364
FICA Taxes	270,944
Employee Health Insurance	481,501
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	3,867
Long Term Disability	10,354
Pension	125,373
Tuition Rembursement	5,993
Employee Activities	2,730
TOTAL (agree to Schedule V, line 22, col.8)	$ 972,384

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,536
Advertising: Employee Recruitment	9,876
Health Care Worker Background Check	
(Indicate # of checks performed)	
Advertising	63,787
P/R & Entertainment	591
Dues - IHCA	15,324
Other Dues	664
Subscriptions	214
Less: Non-allowable subs/recruitment	(500)
Less: Public Relations Expense	(591)
Non-allowable advertising	(60,390)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,511

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,570
Seminar Expense	1,510
Entertainment Expense	( )
(agree to Sch. V,	
TOTAL line 24, col. 8)	$ 3,080

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Carle Arbours # 0028522 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number The Carle Arbours # 0028522 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. **IHCA -$15,324**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15.6**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,127** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **129,790**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,302**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladery & Pullen** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.